Connecticut Department of Social Services
Making a Difference

Testimony before the Human Services Committee
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Good morning, Senator Slossberg and Representative Abercrombie and distinguished members of the Human Services Committee. My name is Roderick Bremby and I am the Commissioner of the Department of Social Services. I am pleased to be before you today to testify on two bills raised on behalf of the department. In addition, I offer written remarks on several other bills on today's agenda that impact the department.

Bills Raised on Behalf of DSS:

H.B. No. 5325 (RAISED) AN ACT ELIMINATING THE HOME-CARE COST CAP.

This proposal would remove the statutory 60% cost cap on waiver services in the Connecticut Home Care Program for Elders. The current 100% cost cap on the overall service plan, both state plan and waiver, would remain in place as costs cannot exceed 100% of the net cost of institutional care.

The department proposed this change because experience has shown us that the cap on waiver services sometimes results in utilizing higher cost state plan services to supplement the waiver service array. Having the cap on waiver services limits care managers' ability to develop cost-effective, person-centered care plans. Furthermore, no other Medicaid waiver administered by DSS has such a limit on waiver services. There is no reason for the distinction between waiver and state plan services since both qualify equally for the 50% federal match.

This bill brings the waiver in line with the remainder of the 1915(c) Medicaid waiver programs but still maintains cost neutrality as required by CMS. This waiver consistently demonstrates cost neutrality and savings to the state as the average cost of waiver and state plan services averages $18,500 per year compared to $60,000 for nursing facility care.

We ask for your support of this proposal.

H.B. No. 5442 (RAISED) AN ACT CONCERNING THE STATE-ADMINISTERED GENERAL ASSISTANCE PROGRAM.

This proposal makes minor and technical changes to remove obsolete provisions concerning statutes governing the State Administered General Assistance (SAGA) program. In addition, this proposal resolves ambiguity in the statute with regard to determining how married recipients are treated. While the statute currently addresses the treatment of unemployable and transitional

"single" individuals, it does not explicitly discuss how married individuals should be treated. In the absence of language, the department has calculated the benefits for these married couples as it would for families that have dependent children; in other words, the standard is based on the percentage of the TFA payment standard and varies depending on the region of the state the recipient lives in. This has led to disproportionate benefit amounts for single individuals versus married couples in certain instances. For example, a married individual in the western region of the state would receive a significantly higher benefit than an unmarried individual would receive in the same region, despite the married recipient having pooled resources at their disposal. By removing the "single" qualifier in this subsection it would eliminate the ambiguity allowing for more equitable benefit awards. The proposal also clarifies the asset limit that is already current policy for married couples.

Lastly, the proposal seeks to clarify section 17b-196 which is intended to pay benefits to a TFA family assistance unit, out of state SAGA funds, for the incremental difference between what the family was receiving when the child qualified as a member of the assistance unit and what the family now receives after the child's disqualification from TFA due to age. However, it recently came to the department's attention that, as written, the existing provision in statute could be read to justify assistance at the level an individual person would receive pursuant to TFA, and that the provision arguably conflicts with the standards of assistance set forth in section 17b-191.

We ask for your support of this proposal.

Additional written remarks to be submitted for the record:

Sections 1, 2 and 3 – At one time, federal rules governing who may be included in a family assistance unit under the Temporary Assistance for Needy Families (TANF) program were fairly strict, and included narrow guidelines with respect to who was considered within the necessary degree of relationship to a child to be included in the child's family assistance unit. Thus, guardians, those applying for guardianship and certain caretaker relatives generally could not be included in the state's TANF-funded program, Temporary Family Assistance (TFA). Instead, these unusual families were captured by the entirely state-funded SAGA program.

However, TANF rules subsequently underwent a liberalization whereby most caretaker relatives, regardless of the degree to which they were related to a child, could be included in the family assistance unit. Thereafter, the U.S. Department of Health and Human Services, through the Administration for Children and Families, released a guidance opinion explaining that, if a state's law provides that a guardian or other individual fulfilling parental responsibilities stands in loco parentis to children in their care, the state may include such guardian or other individual in the child's family assistance unit under TANF law. Because Connecticut law does recognize that guardians and certain other individuals stand in loco parentis to the children in their care, DSS utilized this opinion to transfer qualifying family assistance units from SAGA to federally-funded TFA.

The net result of all of these changes is that the state no longer has families with children on the SAGA ranks. Instead, these families have been transferred to TFA. In fact, because these

families are now eligible for TFA, they are explicitly ineligible for continued assistance under SAGA. See General Statutes § 17b-191(a) "No individual shall be eligible for cash assistance under [SAGA] if eligible for cash assistance under any other state or federal cash assistance program." Accordingly, changes have been made in sections 1 and 2 of this proposed bill that would eliminate outdated references to families in SAGA.

Next, changes in section 2 resolve ambiguity that results from using the qualifier "single" in subsection (b) of section 17b-191, which establishes standards of assistance under SAGA, when describing unemployable and transitional persons without also expressly discussing how married recipients should be treated. As explained above, the agency has calculated benefits for these married recipients as it would for families that include dependent children; that is to say, the standard of assistance is based on a percentage of the TFA payment standard and varies depending on the region of the state in which the recipient lives. This has led to somewhat absurd results, however. For instance, a married couple without dependent children living in region A of the state (western Connecticut) would receive more than twice the amount of assistance that an unmarried unemployable person would receive in the same region. This is problematic because, as a general rule, DSS expects married couples to pool their resources and therefore typically affords a smaller assistance award per married recipient, not a greater award, as is the case in these instances in SAGA. Further, calculating benefits for married recipients in this manner results in the spouses' transitional/unemployable status not being taken into consideration. Thus, a married recipient will receive the same amount of benefits regardless of whether he or she is transitional and not required to pay for shelter, a status that would otherwise entitle an unmarried recipient to approximately $50 per month, as described in subdivision (3) of subsection (b) of section 17b-191.

The department is currently in the process of drafting new regulations that will correct these problems and treat each spouse as an individual recipient for purposes of calculating benefits. DSS proposes eliminating the confusing "single" qualifier in this subsection to rectify the ambiguity described above. DSS also proposes including language that clarifies that the asset limit established in subsection (c) of this section—$250 per person—will be $500 per married couple. This is a rule already followed by the department.

The remaining changes in these sections are technical and conforming changes. For instance, the department proposes eliminating outdated references to town-administered general assistance still contained in subsection (b) of section 17b-191, and including a sentence at the end of subsection (b) of section 17b-191 that cross-references 17b-104, which applies an annual cost of living adjustment to the standards of assistance set forth in 17b-191(b).

Section 4 - Changes to this section are merely intended to remove outdated provisions that were in place when towns continued to administer a general assistance program prior to the state takeover now known as SAGA.

Section 5 – The purpose of section 17b-196 is to ensure that families receiving assistance pursuant to TFA will continue to receive that assistance at the same level after a child who remains in high school is disqualified for continued assistance under federal rules due to attaining the age of 18. In other words, section 17b-196 is intended to pay benefits to a TFA

family assistance unit, out of state SAGA funds, for the incremental difference between what the family was receiving when the child qualified as a member of the assistance unit and what the family now receives after the child's disqualification from TFA due to age. However, it recently came to the department's attention that, as written, the existing provision in statute could be read to justify assistance at the level an individual person would receive pursuant to TFA, and that the provision arguably conflicts with the standards of assistance set forth in section 17b-191. DSS is recommending minor clarifying changes that it believes will eliminate this ambiguity and more clearly reflect the intent of the provision.

S.B. No. 325 (RAISED) AN ACT CONCERNING MEDICAID RECIPIENTS WITH COMPLEX MEDICAL NEEDS.

The Department of Social Services recognizes the importance of these services and we are immensely proud of the many supports we provide our most vulnerable clients. Connecticut's Medicaid program has the most broad and expansive coverage of almost Medicaid program in the country.

While we appreciate the intent of this legislation, the Department believes it can be accomplished more effectively by minor adjustments to the Department's draft regulations governing payment for customized wheelchairs. The Department recognizes that complex rehabilitation technology differs in many ways from other durable medical equipment (DME) where many of these services currently are regulated. Customized wheelchairs represent greater than 90% of complex rehabilitation technology, which the Department has long administered separately from DME. We believe it makes more sense to incorporate the remainder of complex rehabilitation services into the customized wheelchair regulation. Further, the Department is convening a working group made up of industry representatives and consumers to assist us in implementing this regulation; a minor expansion of this working group should serve both purposes.

Nevertheless, DSS must oppose Senate Bill 325 in its current form because it: (1) conflicts with existing requirements, including federal law, recently adopted state law, and Department regulations; (2); will have a substantial increased fiscal impact and (3) is overly prescriptive and impinges on the Department's ability to administer the Medicaid program. The testimony below outlines in detail the specific reasons why the Department must oppose this legislation.

This legislation is in conflict with the Department's draft regulations governing payment for customized wheelchairs. The draft regulations implement state statute (Conn. Gen. Stat. § 17b-278i) and update the existing customized wheelchair regulations to adapt to changes in clinical practice and technology. These regulations were publicly posted on January 31, 2014, public notice was published on February 11, 2014, and there will be a public hearing on the regulations on March 31, 2014. The public comment period for the regulations is open through March 13, 2014. We welcome comments to improve those regulations, including broadening the scope of applicable regulations to include all complex rehabilitation technology.

Finally, the Department is interested in developing a separate and distinct fee schedule and payment methodology to govern these products, recognizing that they are frequently custom manufactured and not 'off the shelf' products. The Department opposes the payment

methodology contained in this legislation as both prohibitively expensive and purposefully opaque. For reasons detailed below, the Department believes a payment methodology based upon the vendor's actual acquisition cost is both more fiscally responsible and fair to the dealers, and we are therefore more than willing to work with the industry to implement these changes.

Finally, the Department estimates that the net cost to the State based on increased fee schedule amounts plus the lost savings associated with the reuse program scheduled to begin in June 1, 2014 could approach $3.6 million per year.

The Department of Social Services additionally opposes this legislation because sections of it conflict with federal and state requirements, are potentially costly, or seriously interfere with the Department's ability to responsibly and effectively administer our programs. The Department must have flexibility to adjust a variety of aspects of the Medicaid program to accommodate changes in clinical practice, changes in federal requirements, and changes in the programs.

Additional written concerns on SB 325 to be submitted for the record:

This bill has several sections which concern the Department for the reasons above, including:

- Section 1(a)(1) – Definition of "Complex needs patient": This definition specifies a variety of diseases but does not take into account the flexibility that the Department's clinical reviewers need in order to determine whether a particular device is medically necessary for an individual. In particular, there is an enormous range in the type and acuity of each of these and other conditions, which also interact with the individual's other medical conditions. Not everyone with multiple sclerosis requires assistance with mobility; nor can all of those with MS and severe secondary dementia operate a motorized wheelchair safely. The medical necessity standard is already established in statute (Conn. Gen. Stat. § 17b-259b) and should not be altered here.

- Section 1(a)(10) – Definition of "Qualified complex rehabilitation technology professional": This definition is overly detailed by listing only one specific organization's certification. Professional standards evolve and improve over time; no one such standard should be etched in statute, just as the Department does not etch such standards in its regulations, but allows the flexibility to adapt those requirements to future improvements in certification standards.

- Section 1(a)(11) – Definition of "Qualified complex rehabilitation technology supplier": As above, a detailed set of provider qualification requirements is not appropriate for inclusion in a statute, but rather belong in the Department's regulations and provider manuals to afford the flexibility to adjust those standards to account for changing needs and requirements.

- Section 1(c)(4) – Setting Minimum Price Levels: Specific rate levels for non-institutional providers are also inappropriate for inclusion in a statute. The Department must have the flexibility to set rates in order to ensure those rates are appropriate for the program and that they comply with applicable federal requirements, especially the requirement to provide for payment rates and methods "to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of

care" and ensure access to care as required under 42 U.S.C. § 1396a(a)(30)(A). Simply requiring the Department to set rates at Medicare levels (or if codes are not covered by Medicare, at manufacturer's suggested retail price minus ten percent) would not give the Department the necessary discretion to be able to analyze any proposed rate changes. In addition, the proposed language would represent a substantial increase from current rates, without any documentation showing how the providers' costs justify such increases. Neither the enacted budget nor the Governor's midterm adjustments include funding for a rate increase.

Specifically, the raised bill includes the following language:

> *The Commissioner shall...*
> *4) establish a payment amount for medically necessary complex rehabilitation technology products and services of*
> *(A) not less than one hundred per cent of the current Medicare fee schedule amount, or*
> *(B) for such products or services individually considered for reimbursement or not covered by Medicare, an amount equal to the manufacturer's suggested retail price minus ten per cent;*

These payment amounts are far higher than the payment amounts in the current DSS policy and on the DME fee schedule, which are priced at approximately 80% of Medicare (for items priced by Medicare). Items not priced by Medicare are currently paid at manufacturer's suggested retail price (MSRP) minus 15%. A revision to pricing policy as proposed would substantially increase payments by the Department for complex rehabilitation equipment. In particular, because custom wheelchairs (which are the large majority of expenditures for complex rehabilitation technology) are paid as a bundled item with some components paid at 80% of Medicare and others at MSRP minus 15%, it is challenging to determine the precise impact. However, assuming all components are priced at 80% of Medicare and payments will increase to 100% of Medicare as proposed in the bill, annual Medicaid expenditures would increase by approximately $2.6 million.

- Section 1(a)(2), Definition of "Complex rehabilitation technology": is ambiguous, especially the undefined references to "functional needs and capacities for basic and instrumental activities of daily living" and has the potential to dramatically increase the expenditures on complex rehabilitation technology. In addition, this definition may be overly broad by including items such as standing frames and gait trainers. Such details regarding subcategories of Medicaid benefits belong in Department regulations and manuals, not in statute, in order to ensure the Department has the flexibility to adapt and change those requirements as needed to conform to program requirements, new clinical practices, and federal requirements. Similarly the definition of "Individually configured" is both vague and overly detailed.

- Section 1(c)(1): Among other things, this subdivision requires the Department to "create new billing codes or code modifiers." That requirement violates federal law because the Department is required by HIPAA only to use HIPAA-compliant codes and modifiers.

- Section 1(c)(3): This subdivision requires the Department to "allow complex rehabilitation technology to be billed to the state Medicaid program as a purchase and paid for in a lump sum payment." First, this provision conflicts with Conn. Gen. Stat. § 17b-278i, as implemented by the Department's proposed customized wheelchair regulations, which require refurbished parts and equipment of customized wheelchairs and other designated devices and equipment to reused whenever practicable. In order to implement that program and as set forth in the Department's proposed customized wheelchair regulations, the Department will need to own customized wheelchairs and equipment and devices after they are purchased—enabling the State to save taxpayer resources by not needing to pay for each device as new even though many components can be safely and easily reused. Second, this provision precludes the Department from requiring all components of a customized wheelchair or other complex rehabilitation technology device to be billed separately, which thus would decrease the clarity of the billing process and prevent the Department from accurately assessing the fiscal impact of proposed changes to pricing. Finally, as written, this language prohibits the Department from reimbursing providers for repairing or modifying existing equipment, which are often faster, better, and more economic options than purchasing new equipment. Savings associated with the reuse program are currently set to begin on June 1, 2014 and are estimated at up to $1 million or more per year when fully implemented. This bill would eliminate these savings entirely. When added to the additional costs noted above, this bill would increase Medicaid expenditures by up to $3.6 million annually.

- Section 1(c)(6): This language would exempt complex rehabilitation technology from "inclusion in any bidding, selective contracting, request for proposal, or similar initiative." That language is overly broad, premature, and conflicts with federal requirements regarding Medicaid crossover claims for equipment or devices covered by Medicare for individuals eligible for both Medicare and Medicaid. The Department does not plan to competitively bid for these services in the Medicaid program, however, the Department should not be precluded from administering the Medicaid program in a way that best meets the needs of our recipients and the State. In addition, federal requirements specifically require the Department to pay Medicare coinsurance and other cost-sharing for items covered by Medicare for certain individuals who are both Medicare and Medicaid members (see 42 U.S.C. § 1396a(n)). Because Medicare established competitive bid programs for certain types of durable medical equipment, this language may conflict with federal requirements for any complex rehabilitation technology as defined in this bill that is part of the Medicare competitive bid program. In addition, because Medicare may change its competitive bid and related programs in the future, such detailed payment requirements should not be hard-coded in statute. The Department needs the flexibility to make sure that it complies with federal requirements governing the Medicaid program.

- Section 1(a)(6) – Definition of "Licensed health care professional" and Section 1 (c) 7: This language is problematic for several reasons. This language appears to allow a member to be evaluated by either a physician, physical therapist, occupational therapist, or other undefined "licensed health care professional who performs specialty evaluations within the professional's scope of practice." Currently in the existing and proposed customized wheelchair regulations, both a physician and an occupational therapist or physical therapist

need to evaluate the patient. Both perspectives are essential to ensure that an occupational therapist or physical therapist has evaluated the patient, since those professionals have unique training and expertise in recommending rehabilitation technology. In addition, a physician (or other primary care provider, such as a physician assistant or advanced practice registered nurse) should also evaluate the individual to ensure, in the context of the individual's overall medical conditions and safety, that a requested item of technology is medically necessary (and clinically appropriate). In addition, because complex rehabilitation technology items require a prescription, they need to be ordered by a practitioner with the scope of practice and legal authority to issue an order, which should be a physician or other primary care provider. Again, such details should not be hard-coded in statute and should be in the Department's regulations. In order to facilitate an efficient evaluation process, the new proposed customized wheelchair regulations substantially increase the flexibility and efficiency of the assessment requirements. The Department welcomes additional public comments on the regulations to improve those requirements further.

S.B. No. 253 (RAISED) AN ACT CONCERNING TEMPORARY NURSING HOME BED REDUCTIONS.

This bill would allow nursing homes to temporarily reduce the number of licensed beds in order to bill bed hold days and receive a higher Medicaid rate based on lower bed capacity. This policy would result in unfunded costs and would not result in increased services or reward quality of care. Additionally, this policy directly contradicts the current rebalancing initiative by reducing the number of available beds while retaining the same institutional infrastructure, effectively negating the cost benefits of the rebalancing efforts. The Department also believes this policy would be administratively burdensome to implement and would likely result in a rapid destabilization of available nursing home beds.

We are also concerned that this bill would place the department in the difficult and arbitrary position of mediating bed reductions and bed restorations between competing facilities across the state. Furthermore, this bill does not provide the Commissioner discretion to deny such rate increase nor specifically allow the Commissioner to rescind the rate increase after a restoration of licensed beds. With approximately 65% of nursing homes below 95% occupancy and assuming most nursing homes with less than 95% occupancy would participate in this policy, it is estimated approximately 1,350 beds would be initially removed from the system in order to access the higher Medicaid rate and bed hold days. Additionally, the Money Follows the Person program anticipates an additional 3,000 nursing home residents will move into community settings over the next several years, greatly adding to the cost of this proposed policy.

The department is opposed to this proposal.

S.B. No. 251 (RAISED) AN ACT CONCERNING PROGRAMS ADMINISTERED BY THE DEPARTMENT OF SOCIAL SERVICES.

This proposal seeks to dictate how documents submitted by recipients are received and processed by the department at the initial intake. While we understand the intent of this bill, we have several significant concerns related to this proposal.

First, we believe this to be largely duplicative of existing regulations and practices with regard to how and where documents may be accepted. The bill is also overly broad to the extent that it fails to distinguish between the numerous types of documents for a wide variety of programs administered by DSS that may be submitted to the Department or its contractors or partners. We believe that this could potentially create operational issues for other entities as they will be required to implement new processes for accepting DSS documents. Lastly, the bill would mandate the department to use inefficient or expensive technologies that have been considered but rejected due to the cost of implementation or maintenance.

The department opposes this proposal as it is duplicative, inefficient and would likely result in administrative costs to the department.

Additional written remarks on SB 251 to be submitted for the record:

Section 1(a)(1)
DSS accepts manually submitted documents at all regional offices. Applications are required by regulation to be accepted at regional offices (UPM 1505.10). DSS has contractors who receive certain documents for processing on behalf of the Department. DSS strongly encourages clients and applicants to provide documents directly to those contractors for faster service, but DSS also accepts manually submitted documents at regional offices even when clients have been instructed to submit documents elsewhere. Requiring acceptance of manually submitted documents in statute is unnecessary as DSS currently accepts documents at regional offices. DSS does not object to this provision but believes it is unnecessary.

Section 1(a)(2)
DSS does not accept all documents by fax due to poor experiences with the technology. DSS has received faxes exceeding 3,300 pages from representatives of Medicaid long-term care applicants. The submission of ineligible, disorganized and massive faxes at our scanning center contributed significantly to initial processing difficulties under ConneCT. Requiring DSS to accept all types of documentation via fax is to mandate an inefficient and aging technology. DSS makes fax submission available when DSS can be assured that the documents that are submitted are appropriate for the technology. For example, one-page expedited Medicaid applications are currently accepted by fax. Requiring the availability of facsimile submission will require widespread document redesigns, IT systems adjustments, and future inefficiency as facsimile becomes an obsolete technology. It will also likely require renegotiation of contracts with current processing vendors with associated costs. DSS objects to this provision.

Section 1(a)(3)
DSS accepts documents through the mail to designated locations. However, this provision could limit our ability to realize cost savings and processing efficiencies.

Section 1(a)(4)
DSS offers clients the ability to apply for benefits online, and will soon offer the ability to submit certain information, such as changes in address and income, through its ConneCT website as well. DSS strongly objects to a statutory requirement that it be required to accept emails with attachments for any type of document. This would require significant IT costs in order to create a secure system with additional firewalls and document screening capacity. This requirement would increase the risk of systemic slowdowns and the possibility of malicious software or viruses that could harm statewide communication systems. It would also require DSS to develop new electronic processes for distributing work in new formats and potentially require software or hardware upgrades to existing systems in the regional offices. DSS has considered offering this option and determined that, at this time, it is not cost-effective nor secure.

Section 1
Applicants and clients are already informed of where they can submit documents. DSS carefully identifies the possible avenues for submission of each document type in order to improve operational efficiency, and encourages clients to use the identified processes to receive faster service. For instance, Medicaid spend-down clients are advised that they will receive faster processing of their medical expenses if they mail the expenses directly to DSS's vendor, instead of manually submitting documents that will then simply be rerouted to that vendor, requiring additional transit time from DSS to the vendor. DSS has drop boxes at each regional office as well as front desk personnel who accept submitted documents. Clients are provided pre-paid envelopes for submission to particular mail locations. Requiring all documents to be submitted anywhere will cause operational inefficiencies, delays in processing and significant operational costs.

Section 1(b) This proposal is largely redundant with existing DSS policy and regulations, and could have significant operational consequences for DSS and the Connecticut Health Insurance Exchange.

Section 1(b)(1)
Date of document receipt is recorded at the regional office and DSS's scanning center. Documents submitted electronically, such as online applications, are considered received when submitted. It should be noted that the date of receipt may not be the date of application, unless the applicant has complied with the minimum requirements for submission of a valid application, such as a name, address and signature for SNAP applications. Nonetheless, per existing regulation, the date of receipt is the date received at a DSS office (UPM 1505.10).

Section 1(b)(2)

Documents received at the Connecticut Health Insurance Exchange are only considered received at such a location if the document submitted was appropriately submitted to the Exchange, such as an application for Medicaid benefits or Medicaid application-related documents. The Department cannot reasonably be expected to have received a document when, hypothetically, a TFA client submits a required employment form to the Exchange. The Exchange is not DSS's agent or partner for the TFA program. By extending the requirement that the Exchange accept all forms of documentation that DSS receives, and in any format as required by this proposed statute, and also require that DSS consider the document received if incorrectly submitted to the Exchange, this proposed statute is likely to have an adverse impact on the operations of both DSS and the Exchange. The Exchange will be required to establish new processes to record the date of hundreds of documents that DSS currently receives and the Exchange does not currently receive, as well as a process for transmitting such incorrectly sent documents to DSS. DSS will have to establish an avenue for receiving and processing such documents, which is likely to be days after the date the document was "received" at an incorrect location. DSS may become liable for any costs associated with the delay in processing such documentation.

Section 1(b)(3)

The date of receipt for documents sent directly to the DSS Scanning Center is the date such documents are received, not the date scanned. The date of receipt for documents dropped off at regional offices and forwarded by DSS to the DSS Scanning Center is the date the documents were submitted at the DSS office, not the date received at the DSS Scanning Center or the date scanned. Date of receipt is electronically associated with the submitted documents at the Scanning Center and within the ConneCT system. This is established policy and practice.

Section 1(b)(4)

This language is overly broad. DSS has numerous agencies and contractors acting on its behalf, not all of whom have the authority or capacity to accept documentation unrelated to their particular service. Only specific agencies and contractors are authorized to accept confidential identifying documentation. DSS carefully selects which agencies and contractors can receive documents from clients and enters into confidentiality agreements and other agreements to ensure proper handling of data. This provision suggests that a Medicaid recipient could drop off medical bills with an emergency shelter provider who DSS contracts with and DSS would have to accept such bills as "received" by DSS. To the extent that certain contractors and partners currently have the authority to accept particular documentation, documents submitted with those contractors and partners are considered received when received by those contractors and partners. The likely intended purpose of this provision is therefore already established practice at DSS and at least somewhat accounted for in regulations with regard to applications (UPM 1505.20).

Section 1(b) "affixing" and "recording . . . [in] online benefits account"

DSS currently records dates electronically in its ConneCT and EMS computer systems. Document receipt dates are visible to DSS workers with access to the computer systems, and records of such data can be provided to clients upon request. Whether electronic documentation of dates is considered "affixing" a date is unclear from the draft language. Furthermore, some document received dates are only available in EMS and not in ConneCT, such as documents

related to Medicaid long-term care applications. Requiring DSS to establish a system that would convert data from EMS to be visible to clients through their "MyAccount" online benefit account would be a prohibitively expensive undertaking for minimal gain and with significant additional financial risk given current efforts to replace EMS entirely under a very tight deadline for federal funding.

Currently, a client or applicant's "online benefits account" shows an applicant what documents DSS has received from that client. Adding a received date to each document or an image of each document may be technologically feasible, but will require IT resources at a time when such resources are at a premium as DSS is in the midst of replacing EMS under extremely tight deadlines for federal funding of the project. Each additional statutory demand that results in IT resources being moved away from EMS replacement threatens the ability of the agency to get federal funds for EMS replacement. DSS expects to receive tens of millions of dollars for the project which is well underway. Given the significant federal reimbursement, the state cannot afford to take such risks.

S.B. No. 250 (RAISED) AN ACT CONCERNING FAIR HEARINGS.

This bill requires DSS to (1) notify any person requesting a hearing that they may have an in-person hearing if there is a "specific need" and that such hearing must be requested; (2) establish a unit for administrative appeals for which the Commissioner must appoint an administrator who must report to the Commissioner and may only be removed for cause; and (3) create an exception to the Uniform Administrative Procedure Act (UAPA) to prohibit DSS hearing officers from communicating with any other employee of the Department, including counsel, unless advance notice is provided to all parties and all parties have the opportunity to participate on the record.

First, with regard to the notification requirement, currently, DSS schedules and provides in-person hearings as requested and necessary. For example, hearings for nursing home residents and people who are homebound are in-person hearings and held where the individual is located. In-person hearings require hearing officers to travel to a home, facility or regional office, which is much more time-consuming than conducting the hearings by video conference. If the Department were required to solicit in-person hearings, the number of those hearings would dramatically increase. The Department already struggles to provide timely hearings; this proposed additional requirement would drain hearings resources even further. The decline in efficiency this presents would require the Department to hire additional hearing officers with the requisite fiscal impact.

Second, requiring the administrative hearings manager to report directly to the Commissioner unnecessarily adds an area of immediate oversight for the Commissioner and interferes with the Commissioner's ability to organize the agency as he sees fit. The current reporting structure complies with federal and state requirements and we do not recommend changing it.

Finally, there is no reason to exempt DSS from a section of the UAPA, section 4-181, which clearly permits hearing officers to communicate with other employees of the Department to receive "aid and advice" from such employees regarding matters of law. To prohibit DSS hearing officers from communicating about agency laws and regulations with other members of the agency without providing advance notice to all parties would severely hamper the accuracy and efficiency of their work. There is no reason why hearing officers should not have the ability to consult with the Department's program and legal staff in order to obtain advice regarding how the agency interprets its laws. DSS administers numerous complex and ever-changing state and federal programs, requiring hearing officers to conduct hearings across a broad range of subject areas and legal requirements. Hearing officers must be impartial to the facts of the case and must apply agency law and regulation consistently. DSS hearing officers should be able to continue to seek assistance in understanding agency law and regulation from other members of the agency without notifying all parties to a hearing and providing opportunity for parties to participate on the record. Such a requirement would be unnecessarily burdensome and time-consuming and it increases the likelihood of erroneous decisions being issued. It is legally unnecessary and would unjustly hamper DSS hearing officers, treating them differently from hearing officers in other state agencies whose actions would continue to be governed by the UAPA.

This proposal strives to make the hearing officer an independent judge, apart from the agency, immune from supervision. The law does not require that degree of separation. Federal Medicaid regulations, for example, require only that the hearing officer must not have been "directly involved in the initial determination of the action in question" (42 CFR § 240(a)(3). 431).

The department is opposed to this proposal.

S.B. No. 254 (RAISED) AN ACT CONCERNING PRESUMPTIVE MEDICAID ELIGIBILITY FOR THE CONNECTICUT HOME-CARE PROGRAM FOR THE ELDERLY.

This bill would provide presumptive eligibility for applicants for the Connecticut Home Care Program for Elders. The department appreciates and shares in the desire to ensure that individuals have prompt access to home care services; however, in its current form we do not believe this proposal is operational given the current allocation of resources and existing department processes for determining eligibility. Additionally, we believe that this could potentially lead to additional administration and staffing costs to the program.

We are concerned that by granting presumptive eligibility, we are removing the incentive to complete the full long-term care application. Once services begin, applicants may not understand the need to still complete an application or to complete one in a timely manner in order to ensure continuity of services. It is difficult to begin receiving services and then have those services taken away if the applicant is subsequently found ineligible rather than delay the implementation of such services to start.

The department does share in the proponent's premise of ensuring timely access to services though, and has initiated a number of measures to assist with this. For example, we designated

four offices as long-term care application processing hubs in October. These hubs are responsible for processing all long-term care applications within a designated catchment area. Each application is assigned to a specific worker, who serves as the point of contact. We expect that this configuration will result in more timely eligibility determinations. We are also currently reviewing long-term care application processing best practices within the four hubs, as well as from other states, to gain greater efficiencies.

In summary, the requirements of this bill would add multiple layers to the eligibility process in time frames that are not achievable. Also, there is the potential for significant costs to the department both for services that ultimately are not eligible for federal match because the application process was never completed as well as the additional staffing costs to be able to complete this process. As an alternative, the department is open to working with stakeholders to review other potential opportunities to accomplish a reduced waiting time for the Home Care program.

H.B. No. 5324 (RAISED) AN ACT CONCERNING MEDICAID APPLICATIONS BY MARRIED PERSONS.

HB 5324 would require that the Department collect extensive data pertaining to the assets of institutionalized Medicaid applicants and their community spouses. This bill is closely related to SB 177, AAC a Community Spouses' Allowable Assets which proposes to increase the amount of assets that the community spouse of an institutionalized Medicaid applicant is allowed to retain to $117,240, the maximum amount permitted under federal law. This amount does not include the home and one car, which community spouses are also allowed to retain. Only thirteen states allow the community spouse to keep the full federal maximum of $117,240 without adjustment as is proposed in this bill.

The Department provided written remarks earlier this session. The Department has opposed increases in the amount of assets protected for community spouses in past years due to our belief it will result in a significant fiscal impact to the state. However, we are willing to explore this further and work with the proponents of SB 177 and the Office of Policy and Management to determine if changes to the program are fiscally feasible at this time.

While quantifiable data will be important to a continuing dialogue, the reporting requirements of HB 5324 are onerous and burdensome. It would require that we conduct two parallel eligibility determinations on every long-term care Medicaid application when a spouse is living in the community, as well as collect, aggregate and report the data proposed by this legislation. HB 5324 would add to the already extensive workload of our staff and would affect our ability to process long-term care Medicaid applications as expeditiously as possible at a time when improving our application timeliness and reducing our pending applications is of paramount importance.

The department is also opposed to the requirement that we report this information to another executive agency head. Executive agencies often work together and share data for the administration of programs; however, we do so in a way that is not intrusive to another's

operations or scope. This bill would create a hierarchal reporting structure between two equal agencies that is inconsistent with the current tenor and operations.

We reiterate our willingness to discuss increases in community spouses' protected assets, including ways to quantify costs in ways that do not place an undue burden on the Department.